EMS OFFICE USE ONLY
Received:
Issued:

APPLICATION FOR CERTIFICATION AS AN "OUTSIDE HOSPITAL"
EMERGENCY MEDICAL SERVICE
SPECIALTY AEROMEDICAL TRANSPORT TEAM

1. SERVICE INFORMATION

Legal Name of Service: _____

Medicare Number: (Optional): _____

ADDRESS	
Mailing	All Geographic/Physical Locations

Head of Service: _____ JobTitle: _____

Telephone of Head of Service: Office:_____
Home:_____
Fax (Business): _____
e-mail contact: _____
Web site: _____
24-hour Dispatch number:_____ ☐ 911 ☐ E-911

For what type of specialty aeromedical transport team certificate are you applying?
(e.g., perinatal, neonatal?) _____

2. CONTINUING AEROMEDICAL EDUCATION

Name of person(s) responsible for continuing aeromedical education program:

#	Name	Contact Telephone
a.		
b.		
c.		
d.		

3. PHYSICIAN MEDICAL DIRECTOR

List all physicians who are qualified under 7 AAC 26.630 and who agree to fulfill the responsibilities outlined in 7 AAC 26.610 - 7 AAC 26.690. (If your service has more than two physician medical directors, provide information for each.) If your physician medical director is affiliated with the Public Health Service or the military, please indicate state(s) of license and license number. The physician medical director(s) must sign below before the application is submitted.

By my signature below, I verify that I will fulfill the requirements in state regulations 7 AAC 26.610-7 AAC 26.690, including annual review of treatment protocols (standing orders). I further verify that the listed personnel have completed the aeromedical training as required in state regulations.

A. _____ _____ _____
Printed Name AK License # Signature

_____ Board Certified? Yes ☐ No ☐
Specialty Training Board Eligible? Yes ☐ No ☐

_____
Aeromedical Training Training Organization Date Completed

_____
Aeromedical Training Training Organization Date Completed

B. _____
Printed Name AK License # Signature

_____ Board Certified? Yes ☐ No ☐
Specialty Training Board Eligible? Yes ☐ No ☐

_____
Aeromedical Training Training Organization Date Completed

_____
Aeromedical Training Training Organization Date Completed

C. Date physician-signed standing orders were last: _____ _____
by physician. Reviewed Revised

4. INFLIGHT PATIENT CARE FORM

If you do not have an EMS report form which meets state requirements, the Alaska Critical Care Air Transport Form (#06-1467) may be obtained from the EMS Unit at P.O. Box 110616, Juneau, AK 99811-0616. Check the appropriate box regarding your EMS inflight Patient Care Report Form:

☐ Enclosed Own Report Form ☐ Service uses Alaska Air Medical Transport Form

Send me _____ Alaska Air Medical Transport Forms.

5. LICENSED PERSONNEL

List all certified or licensed personnel, such as Mobile Intensive Care Paramedics, Physician's Assistants, Nurse Practitioners, Registered Nurses, Certified Emergency Nurses, Critical Care Registered Nurses, or Physicians involved in the transportation and care of patients. Indicate name; license level, number and status; status of aeromedical training; status of medical specialty training; and for personnel recertifying with the service, the number of hours (16 hours per certification period) of continuing medical education in specialized aeromedical patient transportation topics.

Name	Level of License	State License Number[1]	Expiration Date	Date of Initial Aeromedical Training[2]	# Hours of Aeromedical Training in last 2 years[3]	Completion Date	# Hours Special Medical Training	Name of Special Medical Training Organization	Completion Date

1 If the service is not based in Alaska, please list the state in which personnel are licensed and their license numbers.

2 This refers to department-approved training in accordance with 7 AAC 26.370 (a)(3).

3 This refers to special medical training in accordance with 7 AAC 26.330 (d)(2).

6. EQUIPMENT INFORMATION

A. Please attach a list of the medical equipment, drugs, and supplies which will be carried on the aircraft, when appropriate, for the special category of patients being transported. Your list will be reviewed by the State EMS Medical Director. Only equipment needed for each individual patient is required to be on the aircraft at any given time.

B. Do you have sufficient equipment and medications to provide advanced life support procedures which are outlined in the standing orders signed by your physician medical director?
YES ☐ NO ☐

C. Specify equipment needed or missing and your plans to obtain it:

D. Has all equipment been tested in the airborne environment to ensure that it works as designed at high altitudes and does not interfere with the operations of any aircraft in which it will be used?
YES ☐ NO ☐

7. AIRCRAFT INFORMATION FOR PATIENT TRANSPORTS

A. Does the organization/agency have aircraft available 24 hours a day, 7 days a week, to provide patient transport except when flying conditions are unsafe or members of the service are responding to another emergency? YES ☐ NO ☐

B. Does the organization/agency own the aircraft used for transporting patients?
YES ☐ *NO ☐

*If "NO", list below the air carrier(s) with whom the organization/agency has written agreement(s) in order to provide available transport 24 hours a day, 7 days a week, and attach copies of agreements with this application. If there are more than two air carrier written agreements, submit information for each.

WRITTEN AGREEMENTS WITH AIR CARRIERS

_____	_____
Legal Name of Air Carrier	Legal Name of Air Carrier
_____	_____
Mailing Address	Mailing Address
_____	_____
City State Zip Code	City State Zip Code
_____	_____
Name of Agency Head	Name of Agency Head
_____	_____
Business Phone of Agency Head	Business Phone of Agency Head
_____	_____
Agreement Starting/Ending Date	Agreement Starting/Ending Date

C. Please list below the type of aircraft either owned by the Service or expected to be used through written agreement(s) and answer if each aircraft has proper restraining devices and litters. Attach additional sheets as needed.

AIRCRAFT TYPE			RESTRAINING DEVICES	LITTERS
MAKE	MODEL	YEAR	YES/NO	YES/NO
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

8. AFFIRMATION

I hereby affirm that _____(Name of Service) will comply with all rules and regulations of the Department of Health & Social Services (7 AAC 26.310 - 7 AAC 26.400), including:

1) Having one or more certified or licensed Mobile Intensive Care Paramedics, Nurse Practitioners, Physician's Assistants, Registered Nurses, Certified Emergency Nurses, Critical Care Registered Nurses, or Physicians, who have had department-approved aeromedical training, and training in the medical specialty for which the service is to be certified, to provide advanced life support to each patient being transported;

2) Providing a continuing medical education program in aeromedical training that will enable certified or licensed emergency medical personnel to meet state recertification requirements in specialized aeromedical patient transport topics;

3) Ensuring the completion of an approved inflight patient care form for each patient treated. The form must document vital signs and medical treatment given the patient. A copy of the completed inflight patient care form must

   a) accompany the patient to the treatment facility;
   b) be sent to the physician medical director; and
   c) be kept by the specialty aeromedical transport team as a permanent record for five years.

4) If advertising, list in advertisements the levels of licensed medical personnel for the service.

_____
Printed Name of Head of Service

Title:_____

Signature:_____

Date:_____

9. NOTARIZED STATEMENT

In the presence of a notary public, postmaster, clerk of court, judge, magistrate, state trooper, or authorized state employee, if such official is available, applicant must sign here. **I certify under penalty of perjury that the foregoing is true and accurate.**

_____ _____
Signature of Applicant Date

THIS IS TO CERTIFY that on this __ day of _____, 200__, before me appeared _____ to me known and known to me to be the person named in and who executed the foregoing instrument and acknowledged voluntarily signing and sealing the same.

_____
Notary Public, Postmaster, Clerk of Court, Judge, Magistrate, State Trooper, or authorized State employee

My Commission Expires: _____
My Badge Number is _____